NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

MH/DD/SAS Community Systems Progress Indicators

Report for First Quarter SFY 2007-2008

July 1 – September 30, 2007

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December 3, 2007

Quality
NC DMH/DD/SAS

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.

-- William A. Foster. Quotations. Quotations Book, 2005.

Highlights of First Quarter SFY 2007-2008

Services to Persons in Need

- Mental health consumers receiving federal or state funded services in their communities reached the SFY 2008 target for adults (38% served) and exceeded the target set for children by 3% (41% served).
- Developmental disability consumers receiving federal or state funded services in their communities reached the SFY 2008 target for both adults and children (36% and 19% served, respectively).
- Services to adult and child substance abuse consumers fell short (by 3% each) of the SFY 2008 target (7% and 6% served, respectively).

Timely Initiation and Engagement in Service

- Statewide, the SFY 2008 target for initiation of mental health consumers into care was not met in the first quarter (fell short by 3%) with only 39% of consumers receiving 2 visits within the first 14 days of care. However, the SFY 2008 target for engagement of these consumers was exceeded by 2% in the first quarter (27% of consumers had 4 visits within 45 days of care).
- The SFY 2008 targets for initiation as well as engagement of developmental disability consumers into care were not met in the first quarter. Sixty-three percent of these consumers received 2 visits within the first 14 days of care (compared to the 72% target) and 52% had 4 visits within 45 days of care (compared to the 55% target).
- The SFY 2008 targets for initiation as well as engagement of substance abuse consumers into care were not met in the first quarter. Sixty-four percent of these consumers received 2 visits within the first 14 days of care (compared to the 71% target) and only 47% had 4 visits within 45 days of care (compared to the 50% target).

Effective Use of State Psychiatric Hospitals

- Consumers receiving short term care (1 to 7 days) in state psychiatric hospitals did not meet the SFY 2008 target; in fact, at 56% of consumers in for stays a week or less, this measure was 12% over the SFY 2008 target of 44% or less of consumers admitted to state psychiatric hospitals for stays of 7 days or less.

Timely Follow-Up after Inpatient Care

- The SFY 2008 targets for follow-up care for consumers discharged from ADATCs or state psychiatric hospitals were not met in the first quarter (28% and 29% of consumers seen in 1 to 7 days, respectively).

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Introduction

Tracking the effectiveness of community systems provides a means for the public and General Assembly to hold the Division of MH/DD/SAS, the Local Management Entities (LMEs), and provider agencies accountable for progress toward the goals of the system reform.[1] Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.

Each topic covered by these indicators involves substantial "behind-the-scenes" activity by service providers, LME and state staff, consumers, and family members. These indicators do not purport to cover all of those efforts. Instead, they address the desired results of those activities as a way to guide decisions about more detailed analysis by system stakeholders into issues that affect progress toward the goals of MH/DD/SAS system transformation. The indicators were chosen to reflect:

- accepted standards of care,
- fair and reliable measures, and
- readily available data sources.

The following pages present graphs showing the progress of each LME on the selected indicators for the most recent time period available.[2] Measures relying on service claims data are delayed by 90 to 180 days to allow time for claims to be processed.[3] The source information below each graph provides details on the data systems and time periods used.

Formulas for calculating the indicators as well as tables showing the statistics for each LME on all indicators are available in a separate document, the *Appendices for MH/DD/SAS Community Systems Progress Indicators.* Both are available on the Division website at:

http://www.ncdhhs.gov/mhddsas/statspublications/reports

For SFY 2007-2008, the Division has redesigned the Community Systems Progress Indicators Report to include statewide targets to be achieved by the end of the fiscal year. These targets are indicated by a red line across the graphs on the following pages. The Division has set higher targets for areas of greatest concern, notably seeking the greatest improvements in substance abuse services and in decreased use of state psychiatric hospitals.

The indicators and targets in this report mirror topics chosen as performance measures for the SFY 2007-2008 DHHS-LME Performance Contract. Performance standards required by the Contract are noted at the bottom of each graph. However, the emphasis of the Community Systems Progress Indicators Reports remains on highlighting gains made toward desired results

[1] This report fulfills the requirements of S.L. 2006-142 (HB 2077) that directs the Department of Health and Human Services to develop critical indicators of LME performance. Measures reflect the goals of the NC State Plans 2000-2006, the President's New Freedom Initiative, CMS' Quality Framework for Home and Community Based Services, and SAMHSA's Federal Action Agenda and National Outcome Measures.

[2] A list of counties that make up each LME is available in the Report Appendix.

[3] Data on service claims for Piedmont are not available for this report and noted by an asterisk in graphs where applicable.

rather than compliance with basic requirements.[4] For this reason, a text box has been added to each graph that highlights the number of LMEs that achieved the fiscal year target during the reporting period.

In addition to the indicators charted in the following pages, the Division is working on three additional indicators that will be added to the report during this fiscal year.

- ***Readmissions to State Psychiatric Hospitals***

  Successful community living, without repeated admissions to inpatient psychiatric care, requires effective coordination and ongoing appropriate levels of community care after hospitalization. A low psychiatric hospital readmission rate is a nationally accepted standard of care that indicates how well a community is assisting individuals at risk for repeated hospitalizations.

  The Division will use data from the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) on discharges from the psychiatric hospitals to calculate the number of discharges with a readmission within the reported time period (30 days and 180 days).

- ***Timely Access To Services***

  When an individual makes a request for service, quick response with the appropriate level of care is a gauge of the system's service capacity and coordination efforts. The Division's standards for access include providing care within two hours of request in emergent situations, within 48 hours in urgent situations, and within 10 working days in routine situations.

  In January 2006 LMEs began submitting information to the Division on all persons requesting services. This data will be matched to service claims data to determine the percent of persons who received necessary emergent services within 2 hours of request, urgent services within 48 hours, and routine services within 7 days.

- ***Child Services in Family Settings***

  Services provided in a child's home community, particularly in a family setting, promote the achievement of long-term stability that comes from a sense of belonging. Children and adolescents served in the most natural and least restrictive community settings appropriate to their needs are more likely to maintain or develop positive family and community connections and to achieve other lasting, positive outcomes.

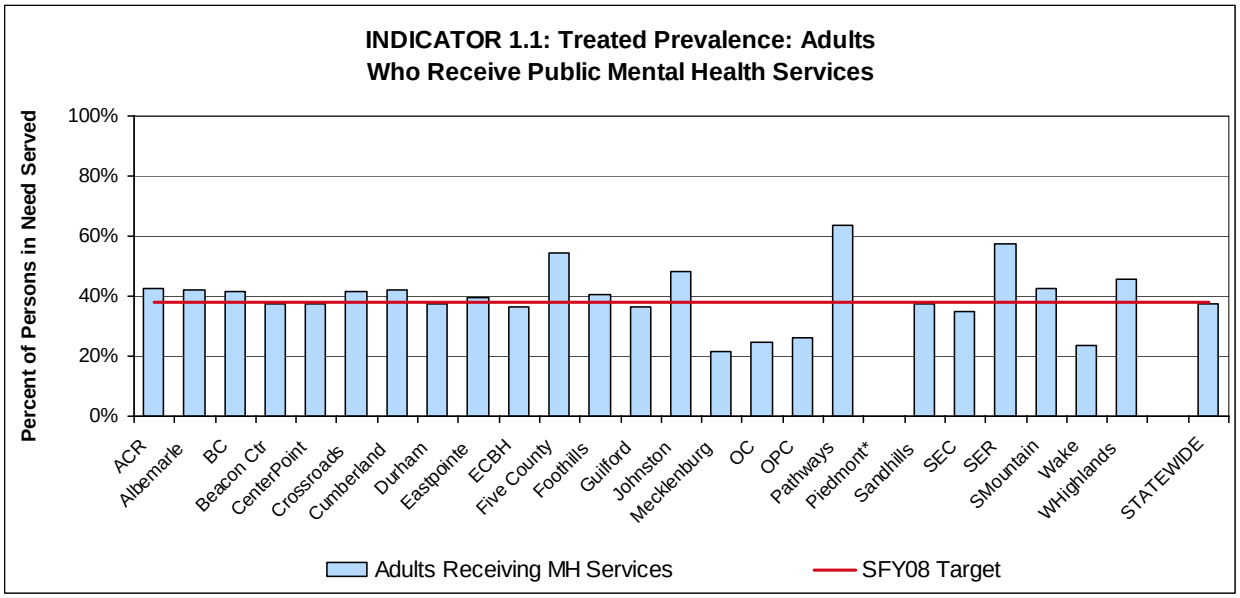
  The Division will use service claims data to calculate the number of children and adolescents in each LME who receives Level II (Program-type only), Level III and/or Level IV residential services as a percent of all children and adolescents served by the LME during the reported quarter. The goal is to reduce the percent of children and adolescents served in these settings over time, while increasing those served while living with their natural families or with therapeutic foster families (Level II Family-type residential services).

[4] Beginning with the third quarter of this fiscal year, the Community Systems Progress Indicators Report will replace the current Quarterly DHHS-LME Performance Contract Reports.

Indicator 1: Services to Persons in Need

1.1 Adult Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2007; N=342,218 adults in need

Statewide, 128,883 adults (38% of those in need of services[5]) received federal or state funded MH services through our community service system from July 2006 through June 2007.[6] The rate of adults who were served varied among LMEs from a low of 22% (Mecklenburg) to a high of 63% (Pathways).

The established SFY 2008 target for persons receiving adult mental health services is 38% or higher, as indicated by the red line in the graph above[7]. Of the 24 LMEs reporting, 14 LMEs met or exceeded the target.

[5] URS Table 1: Number of Persons with Serious Mental Illness [*sic*], age 18 and older, by State, 2006, Midpoint of range between lower and upper limits of estimate. Prepared by NRI/SDICC for CMHS: August 29, 2006. Estimates applied to county population as of July 2007.

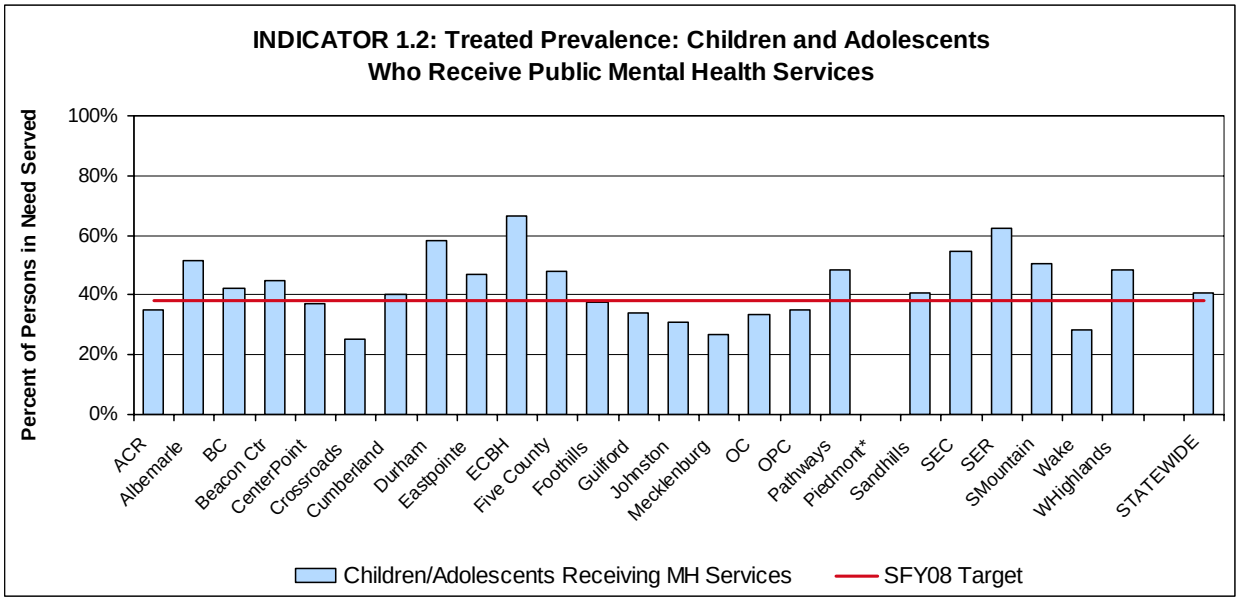
[6] The numbers served reflect adults, ages 18 and over, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private funds. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[7] The SFY 2008 DHHS-LME Performance Contract requirement is 38% or above.

Indicator 1: Services to Persons in Need

1.2 Child and Adolescent Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2007; N=201,155 children and adolescents in need

Statewide, 82,363 children and adolescents (41% of those in need of services[8]) received federal or state funded MH services through our community service system from July 2006 through June 2007.[9] The rate of those served varied from a low of 25% (Crossroads) to a high of 67% (ECBH).

The established SFY 2008 target for persons receiving child mental health services is 38%, as indicated by the red line in the graph above[10]. Of the 24 LMEs reporting, 14 LMEs met or exceeded the target.

[8] URS Table 1: Number of Children with Serious Emotional Disturbances [*sic*], age 9 to 17, by State, 2006, Level of functioning score=60, midpoint of range between lower and upper limits of estimates. Prepared by NRI/SDICC for CMHS: August 29, 2006. The Division applies the estimates established by CMHS for children ages 9-17 to those under the age of 9, since no established estimates exist for younger children. Estimates applied to county population as of July 2007.

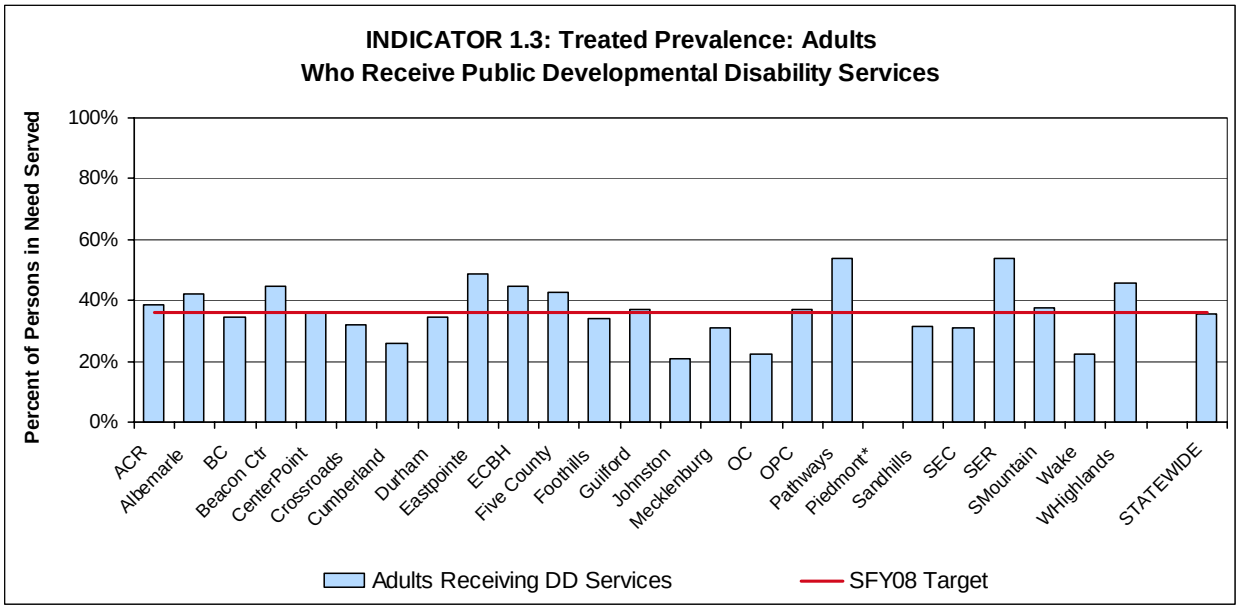
[9] The numbers served reflect children and adolescents, ages 3-17, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private funds. The NC Division of Public Health is responsible for all services from birth through age 2. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[10] The SFY 2008 DHHS-LME Performance Contract requirement is 38% or above.

Indicator 1: Services to Persons in Need

1.3 Adult Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2007; N=50,008 adults in need

Statewide, 17,879 adults (36% of those in need of services[11]) received federal or state funded DD services through our community service system from July 2006 through June 2007.[12] The rate of adults who were served varied among LMEs from a low of 21% (Johnston) to a high of 54% (Pathways and Southeastern Regional).

The established SFY 2008 target for persons receiving adult developmental disability services is 36%, as indicated by the red line in the graph above[13]. Of the 24 LMEs reporting, 13 LMEs met or exceeded the target.

[11] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Age appropriate estimates applied to county population as of July 2007 (See *Appendix*).

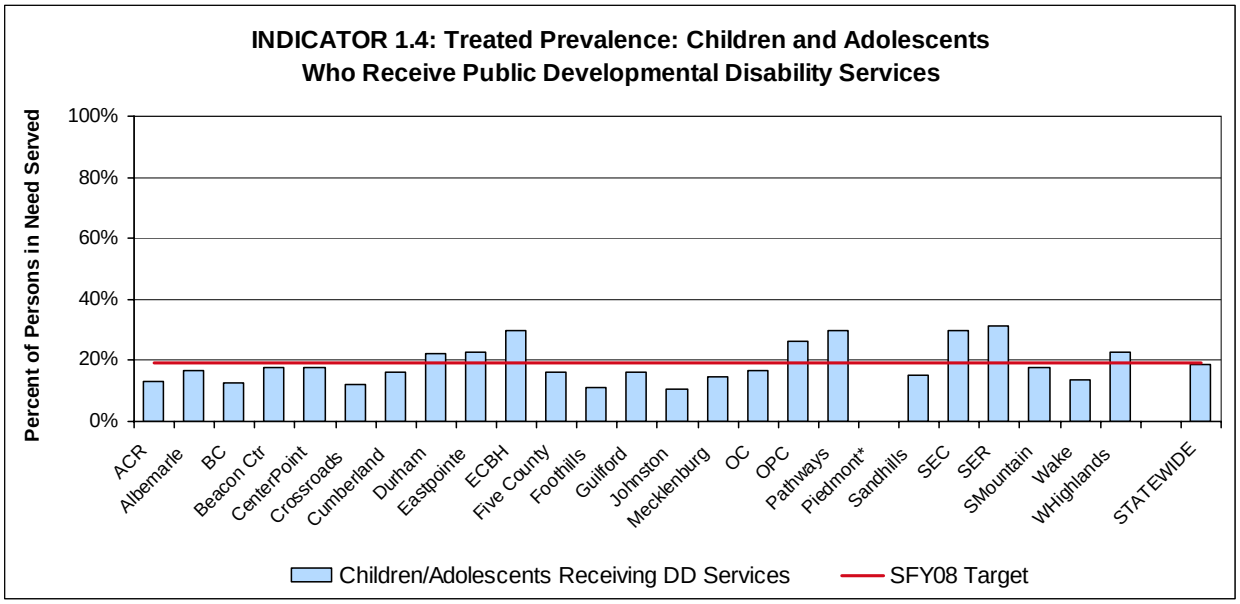
[12] The numbers served reflect adults, ages 18 and over, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[13] The SFY 2008 DHHS-LME Performance Contract requirement is 36% or above.

Indicator 1: Services to Persons in Need

1.4 Child and Adolescent Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2007; N=53,737 adolescents in need

Statewide, 9,977 children and adolescents (19% of those in need of services[14]) received federal or state funded DD services through our community service system from July 2006 through June 2007.[15] [16] The rate of those who were served varied among LMEs from a low of 11% (Foothills and Johnston) to a high of 31% (Southeastern Regional).

The established SFY 2008 target for persons receiving child developmental disability services is 19%, as indicated by the red line in the graph above[1]. Of the 24 LMEs reporting, 8 LMEs met or exceeded the target.

[14] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Age appropriate estimates applied to county population as of July 2007 (See *Appendix*).

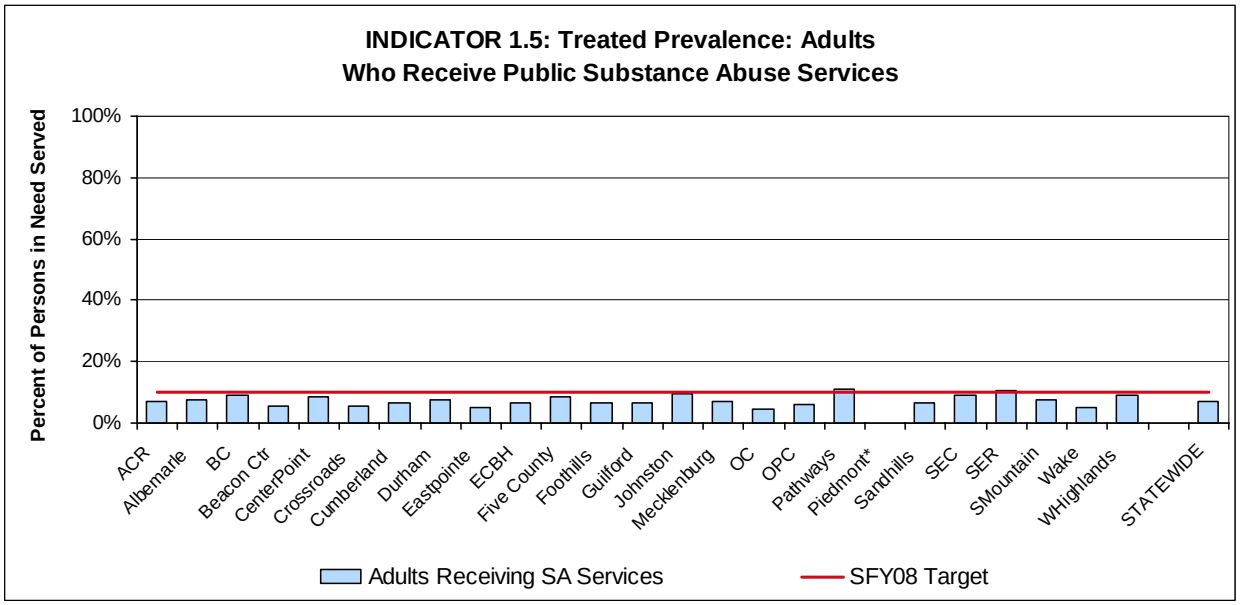
[15] The numbers reflect children and adolescents, ages 3-17, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[16] The NC Division of Public Health is responsible for all services from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.

Indicator 1: Services to Persons in Need

1.5 Adult Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2007; N=559,892 adults in need

Statewide, 40,588 adults (7% of those in need of services[17]) received federal or state funded SA services through our community service system from July 2006 through June 2007.[18] The rate of adults who were served varied among LMEs from a low of 4% (Onslow-Carteret) to a high of 11% (Pathways and Southeastern Regional).

The established SFY 2008 target for persons receiving adult substance abuse services is 10%, as indicated by the red line in the graph above[19]. Of the 24 LMEs reporting, only 2 LMEs (Pathways and Southeastern Regional) met or exceeded the target.

[17] *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health*, Table B.20, http://oas.samhsa.gov/nsduh.htm. Age appropriate estimates applied to county population as of July 2007 (See *Appendix*).

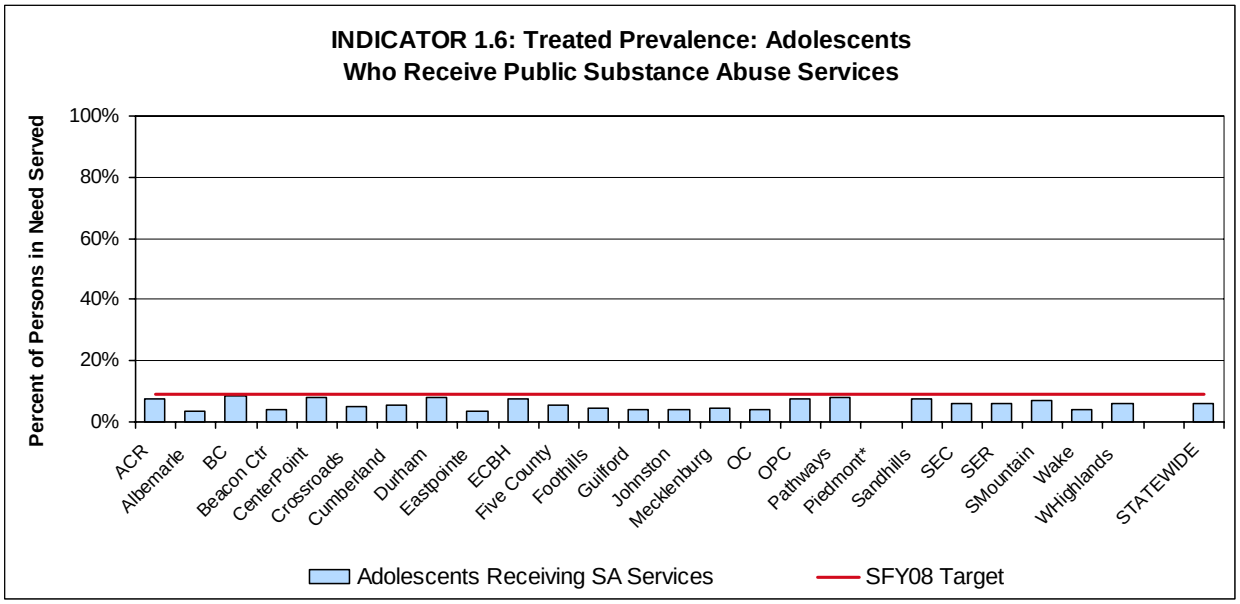
[18] The numbers served reflect adults, ages 18 and over, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[19] The SFY 2008 DHHS-LME Performance Contract requirement is 8% or above.

Indicator 1: Services to Persons in Need

1.6 Adolescent Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2007; N=54,188 adolescents in need

Statewide, 3,152 adolescents (6% of those in need of services[20]) received federal or state funded services through our community service system from July 2006 through June 2007.[21] The rate of targeted adolescents who were served varied among LMEs from a low of 4% (Albemarle, Beacon Center, Eastpointe, Guilford, Johnston, Onslow-Carteret, and Wake) to a high of 9% (Burke-Catawba).

The established SFY 2008 target for persons receiving child substance abuse services is 9%, as indicated by the red line in the graph above[22]. Of the 24 LMEs reporting, only 1 LME (Burke-Catawba) met or exceeded the target.

[20] *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health,* Table B.20, http://oas.samhsa.gov/nsduh.htm. Estimates applied to county population as of July 2007.

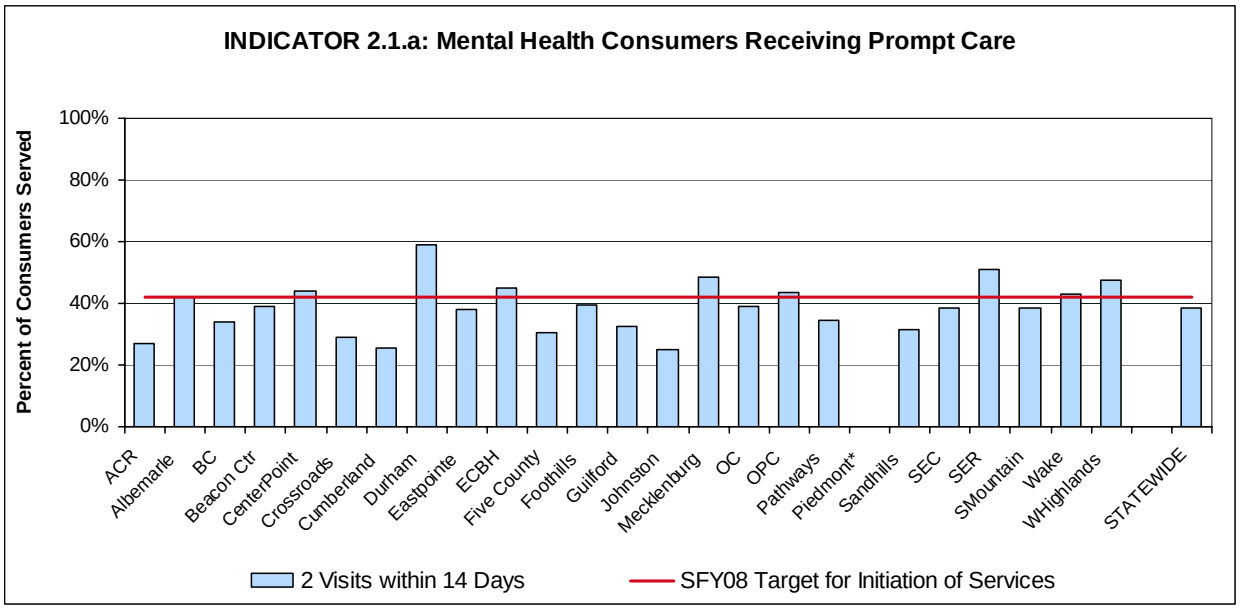
[21] The numbers served reflect adolescents, ages 12-17, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[22] The SFY 2008 DHHS-LME Performance Contract requirement is 7% or above.

Indicator 2: Timely Initiation and Engagement in Service

2.1.a Initiation of Mental Health Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=49,406 consumers

Approximately two-fifths (39%) of NC residents (all age groups) who received mental health services had two visits in the first 14 days of care, which is the standard for prompt initiation of care. Among LMEs, this percent ranges from a low of 25% (Johnston) to a high of 59% (Durham). Compared to the other disability groups, consumers with mental illness wait longer on average for initiation of care.

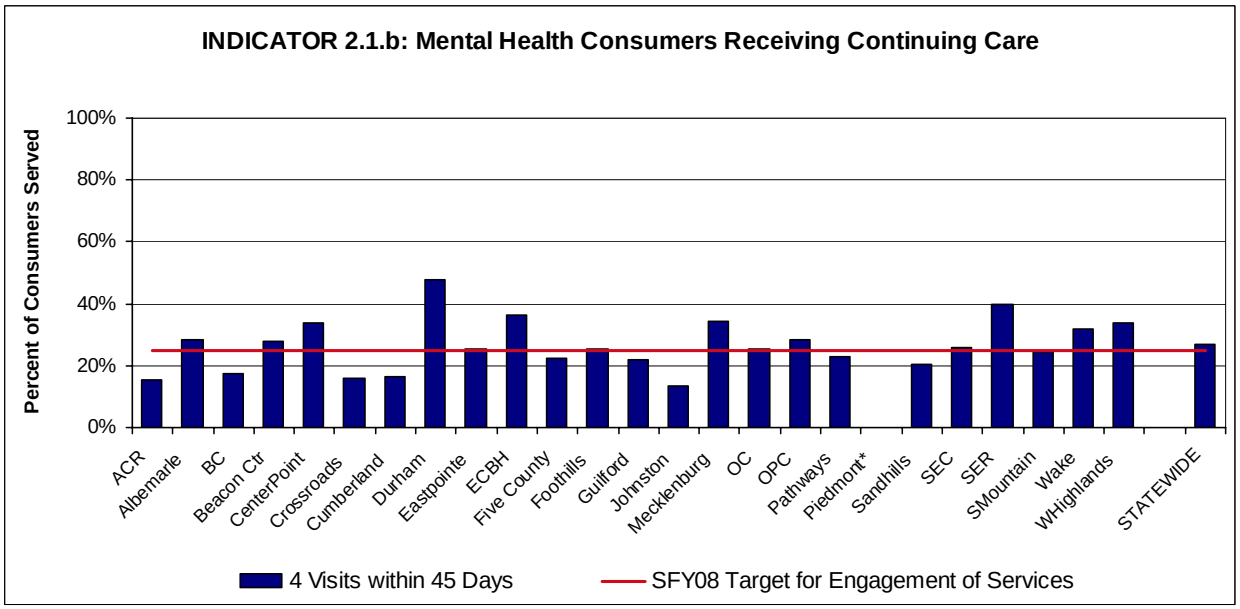
The established SFY 2008 target for initiation of mental health consumers into care is 42%, as indicated by the red line in the graph above[23]. Of the 24 LMEs reporting, over one-third of the LMEs (9 LMEs) met or exceeded the target.

[23] The SFY 2008 DHHS-LME Performance Contract requirement is 35% or above.

Indicator 2: Timely Initiation and Engagement in Service

2.1.b Engagement of Mental Health Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=49,406 consumers

Just over one-fourth (27%) of mental health consumers who met the initiation standard (two visits within 14 days of care) had an additional two visits within the next 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 14% (Johnston) to a high of 48% (Durham).

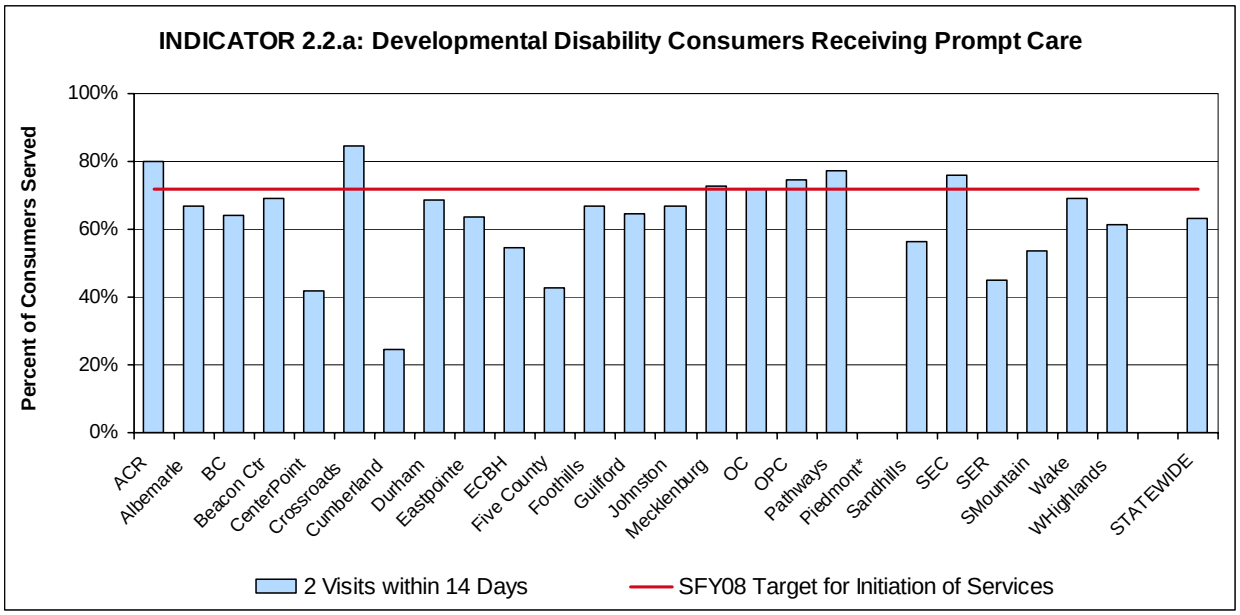
The established SFY 2008 target for engagement of mental health consumers into care is 25%, as indicated by the red line in the graph above[24]. Of the 24 LMEs reporting, well over half of the LMEs (14 LMEs) met or exceeded the target.

[24] The SFY 2008 DHHS-LME Performance Contract requirement is 21% or above.

Indicator 2: Timely Initiation and Engagement in Service

2.2.a Initiation of Developmental Disability Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=1,013 consumers

Sixty-three percent (63%) of NC residents (all age groups) who received developmental disability services/supports had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 24% (Cumberland) to a high of 85% (Crossroads).

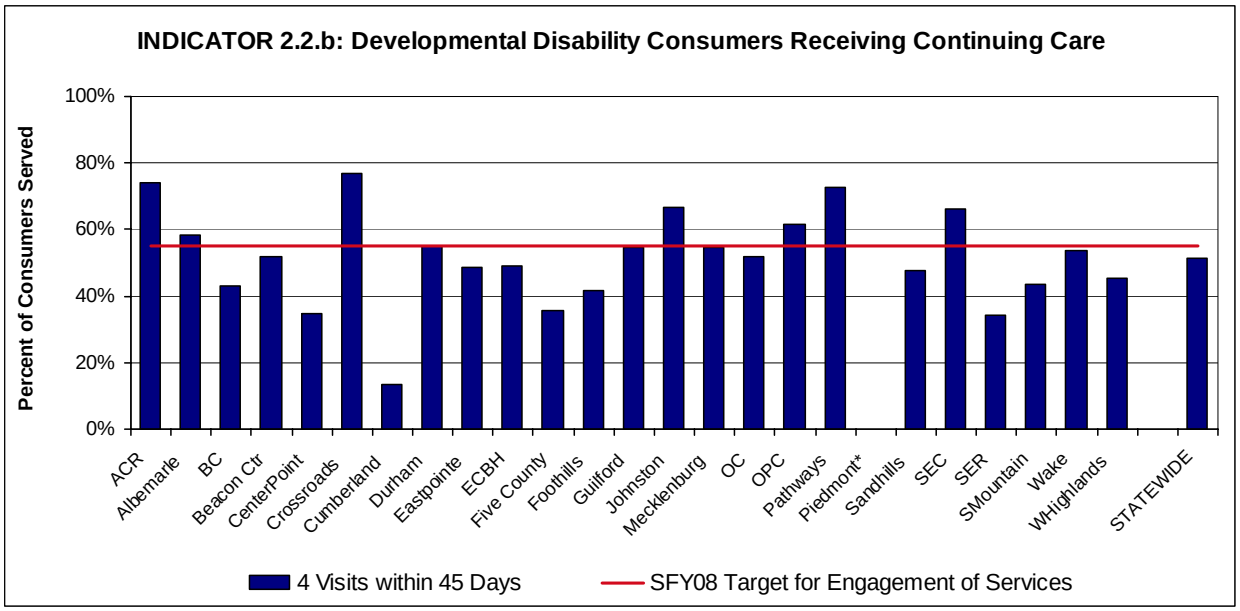
The established SFY 2008 target for initiation of developmental disability consumers into care is 72%, as indicated by the red line in the graph above[25]. Of the 24 LMEs reporting, 7 LMEs met or exceeded the target.

[25] The SFY 2008 DHHS-LME Performance Contract requirement is 60% or above.

Indicator 2: Timely Initiation and Engagement in Service

2.2.b Engagement of Developmental Disability Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=1,013 consumers

Over half (52%) of developmental disability consumers who met the initiation standard (two visits within 14 days of care) had an additional two visits within 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 13% (Cumberland) to a high of 77% (Crossroads).

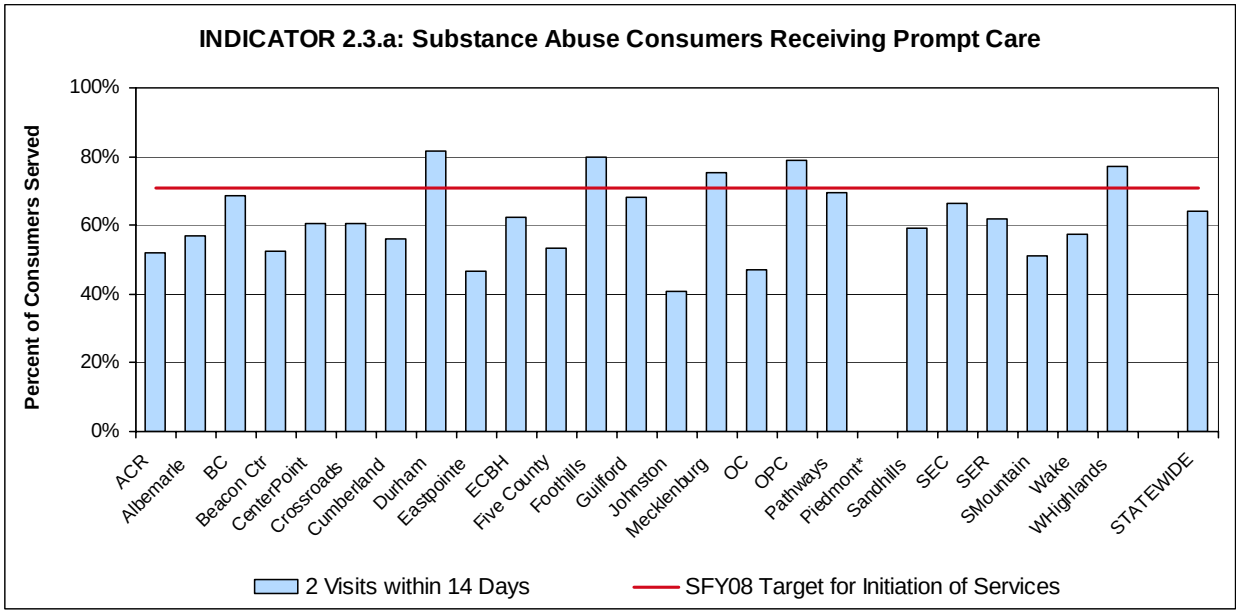
The established SFY 2008 target for engagement of developmental disability consumers into care is 55%, as indicated by the red line in the graph above[26]. Of the 24 LMEs reporting, over one-third of the LMEs (9 LMEs) met or exceeded the target.

[26] The SFY 2008 DHHS-LME Performance Contract requirement is 46% or above.

Indicator 2: Timely Initiation and Engagement in Service

2.3.a Initiation of Substance Abuse Consumers

Rationale: National standards[27] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=4,827 consumers

Slightly under two-thirds (64%) of NC residents (all age groups) who received substance abuse services had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 41% (Johnston) to a high of 82% (Durham).

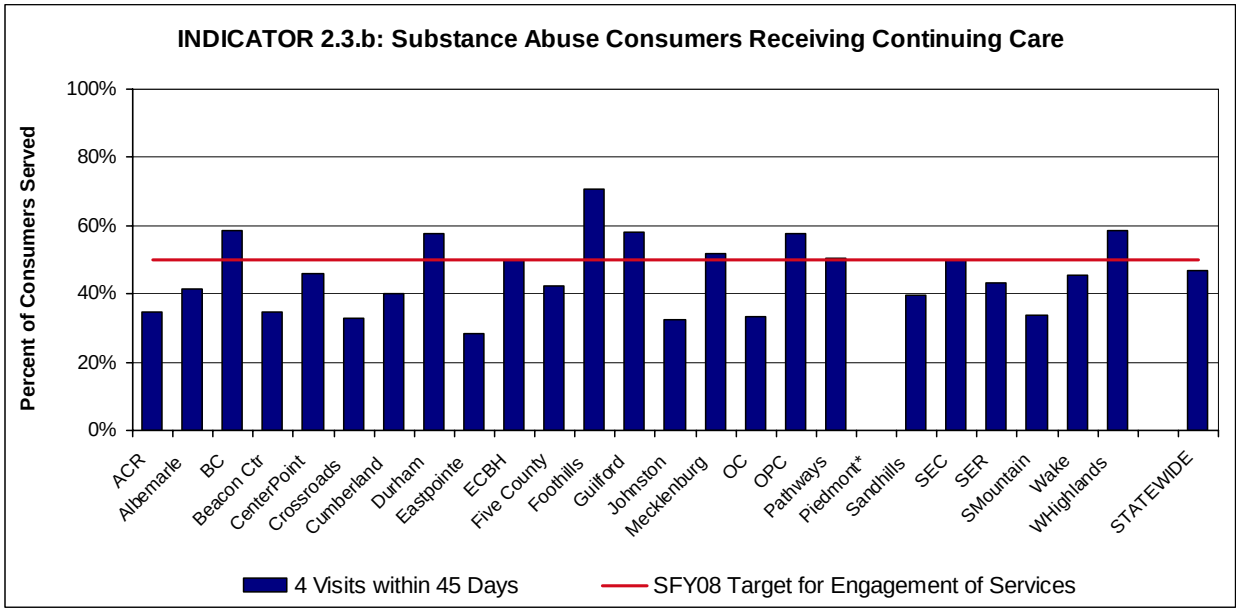
The established SFY 2008 target for initiation of substance abuse consumers into care is 71%, as indicated by the red line in the graph above[28]. Of the 24 LMEs reporting, 5 LMEs met or exceeded the target.

[27] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.
[28] The SFY 2008 DHHS-LME Performance Contract requirement is 59% or above.

Indicator 2: Timely Initiation and Engagement in Service

2.3.b Engagement of Substance Abuse Consumers

Rationale: National standards[29] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=4,827 consumers

Slightly less than half (47%) of substance abuse consumers who met the initiation standard (two visits within 14 days of care) had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 28% (Eastpointe) to a high of 71% (Foothills).

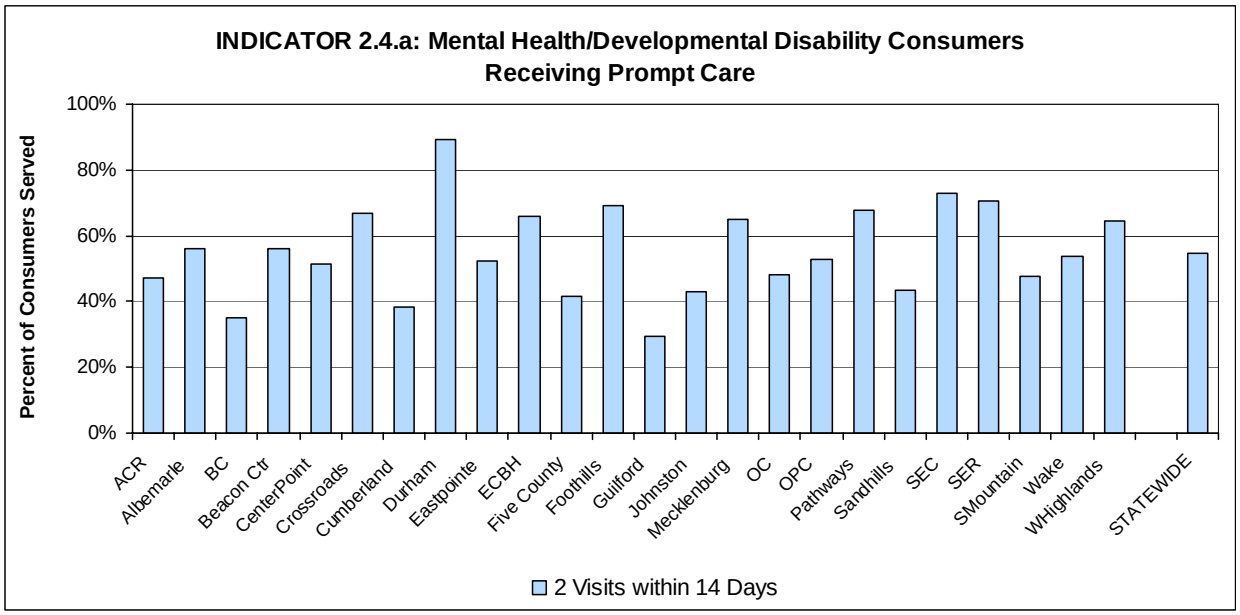
The established SFY 2008 target for engagement of substance abuse consumers into care is 50%, as indicated by the red line in the graph above[30]. Of the 24 LMEs reporting, 10 LMEs met or exceeded the target.

[29] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.
[30] The SFY 2008 DHHS-LME Performance Contract requirement is 42% or above.

Indicator 2: Timely Initiation and Engagement in Service

2.4.a Initiation of Co-Occurring Mental Health/Developmental Disability Consumers

Rationale: National standards[31] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=1,162 consumers

Over half (55%) of NC residents (all age groups) who received both mental health and developmental disability services had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 29% (Guilford) to a high of 90% (Durham).

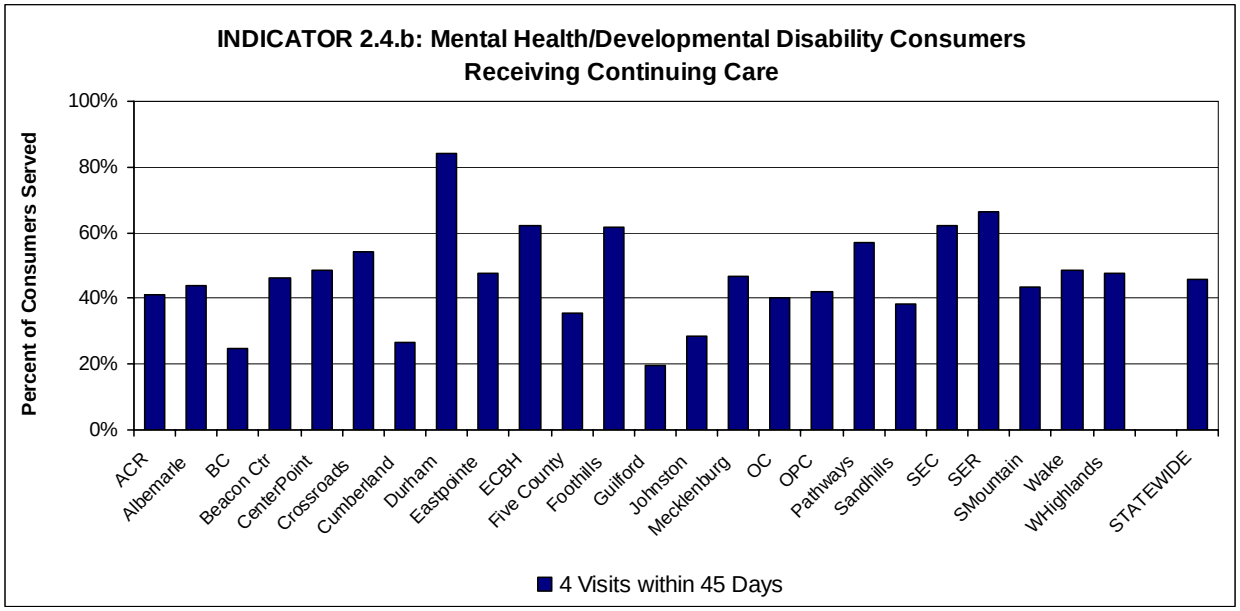
A SFY 2008 target for initiation for consumers in need of co-occurring mental health and developmental disability services has not yet been established.

[31] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 2: Timely Initiation and Engagement in Service

2.4.b Engagement of Co-Occurring Mental Health/Developmental Disability Consumers

Rationale: National standards[32] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=1,162 consumers

Just under half (46%) of NC consumers who received both mental health and developmental disability consumers met the initiation standard of two visits within 14 days and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 20% (Guilford) to a high of 84% (Durham).

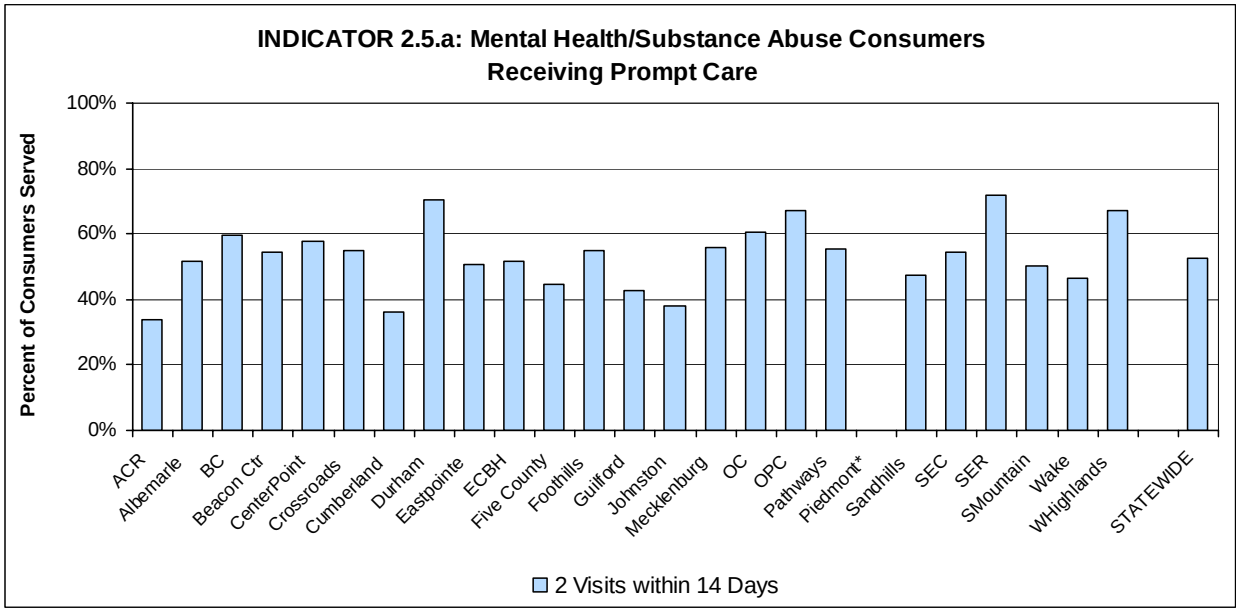
A SFY 2008 target for engagement for consumers in need of co-occurring mental health and developmental disability services has not yet been established.

[32] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 2: Timely Initiation and Engagement in Service

2.5.a Initiation of Co-Occurring Mental Health/Substance Abuse Consumers

Rationale: National standards[33] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=5,864 consumers

Just over half (53%) of NC residents (all age groups) who received both mental health and substance abuse services had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 34% (Alamance-Caswell-Rockingham) to a high of 72% (Southeastern Regional).

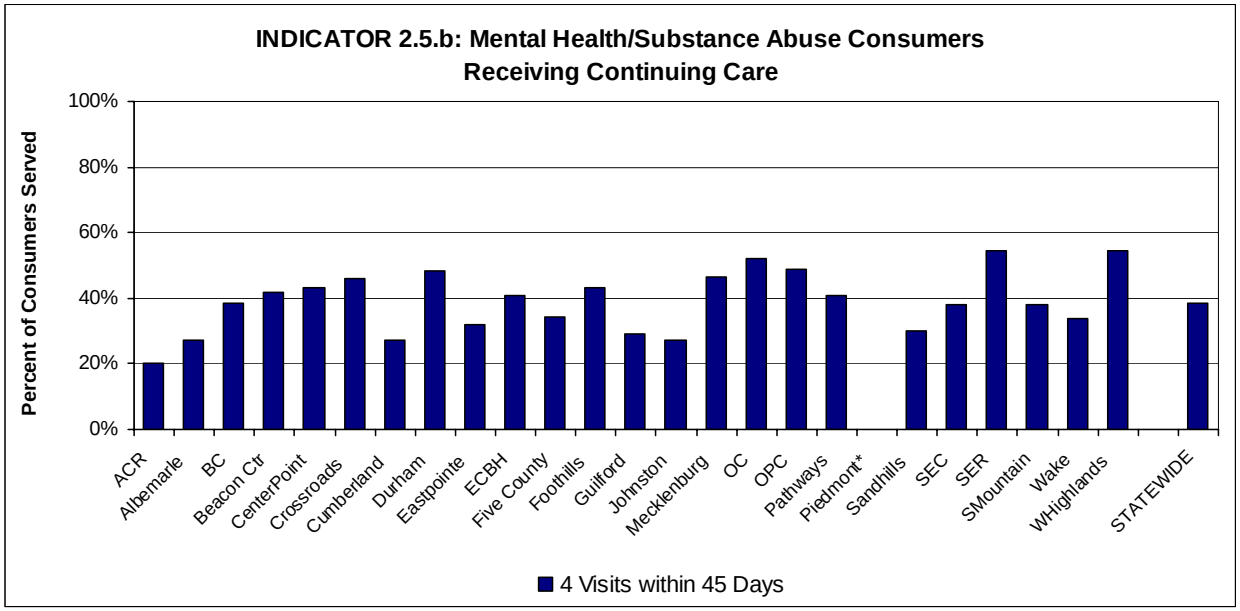
A SFY 2008 target for initiation for consumers in need of co-occurring mental health and substance abuse services has not yet been established.

[33] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 2: Timely Initiation and Engagement in Service

2.5.b Engagement of Co-Occurring Mental Health/Substance Abuse Consumers

Rationale: National standards[34] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2007 (first service received); N=5,864 consumers

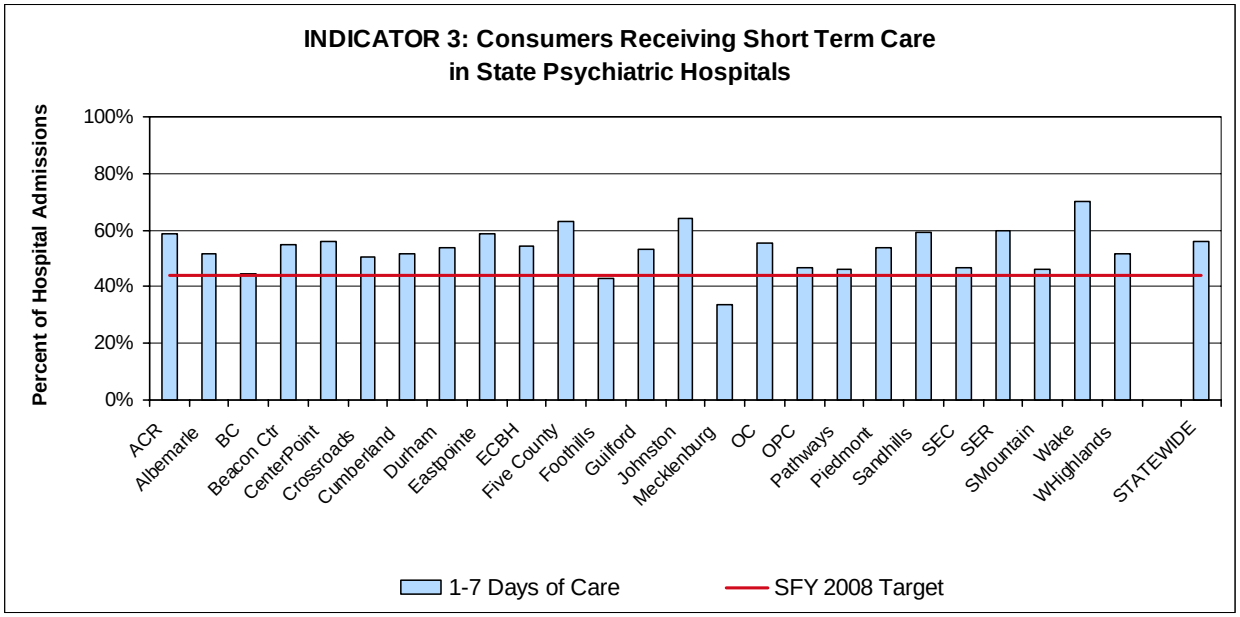
Approximately two-fifths (39%) of NC consumers who received both mental health and substance abuse consumers met the initiation standard of two visits within 14 days and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 20% (Alamance-Caswell-Rockingham) to a high of 55% (Southeastern Regional).

A SFY 2008 target for engagement for consumers in need of co-occurring mental health and substance abuse services has not yet been established.

[34] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 3: Effective Use of State Psychiatric Hospitals

Rationale: State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis services and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. *Reducing* the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for discharges during April 1 - September 30, 2007; N=8,156 discharges

Of the statewide hospital discharges from March through September 2007, over half (56% or 4,586) were hospitalized for 1-7 days. (Note: As seen in the *Appendix*, 31% (2,519) were hospitalized for 8-30 days). Lengths of stay for 1-7 days varied by LME from a high of 70% (Wake) to a low of 33% (Mecklenburg).

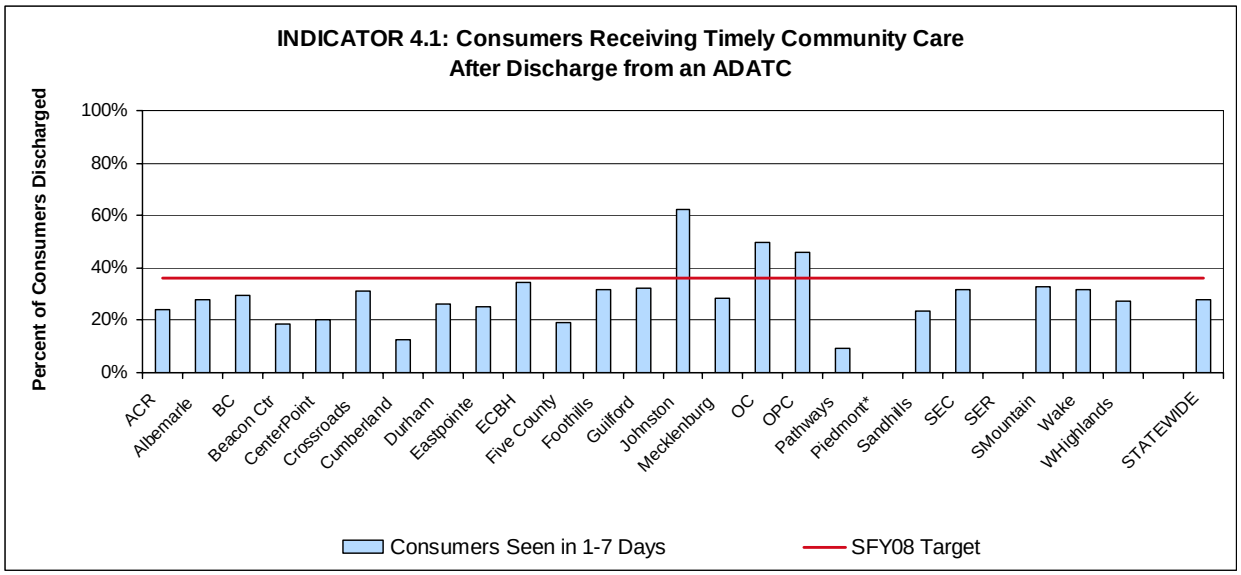
The established SFY 2008 target for short-term (1-7 day) use of state psychiatric hospitals is no more than 44%, as indicated by the red line in the graph above[35]. Of the 25 LMEs reporting, only 2 LMEs (Foothills and Mecklenburg) met or exceeded the target.

[35] The SFY 2008 DHHS-LME Performance Contract requirement is 55% or below.

Indicator 4: Timely Follow-Up after Inpatient Care

4.1 ADATCs

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[36]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges January 1 - March 31, 2007); Medicaid and State Service Claims Data (for claims submitted January 1 - September 30, 2007); N=837 discharges

Twenty-eight percent of consumers discharged from an ADATC received follow-up care in the community within 7 days. An additional 12% of NC consumers were seen within 8-30 days of discharge (not shown in the graph above; see *Appendix*).

Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 0% (Southeastern Regional) to a high of 63% (Johnston).

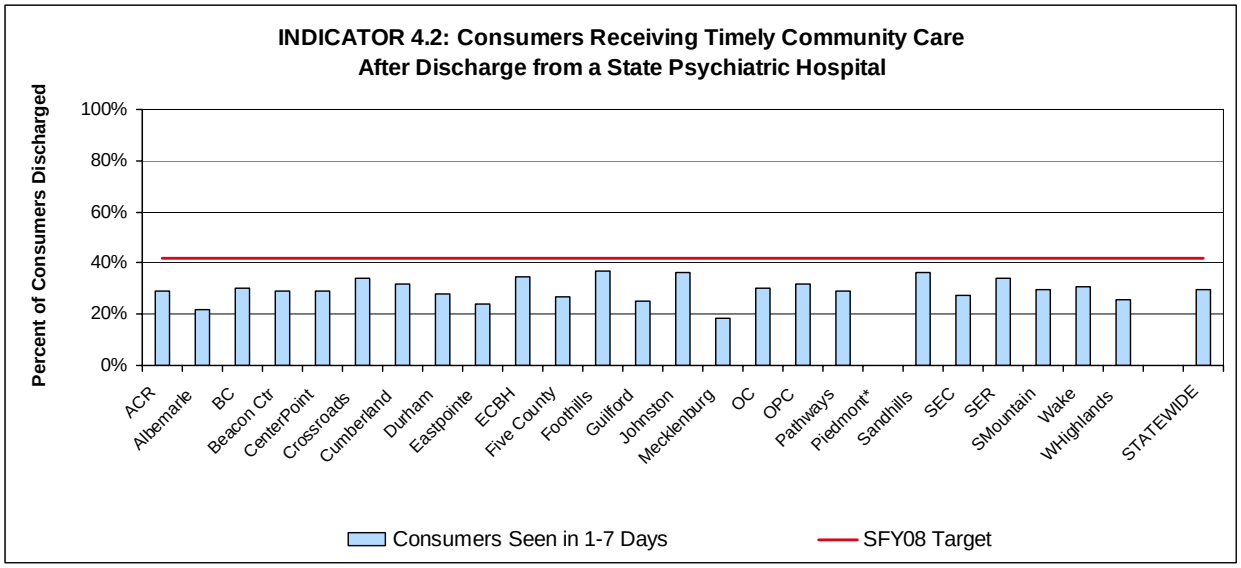
The established SFY 2008 target for follow-up care in the community within 7 days of discharge from an ADATC is 36%, as indicated by the red line in the graph above[37]. Of the 24 LMEs reporting, three LMEs (Johnston, Onslow-Carteret, and OPC) met or exceeded the target.

[36] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.
[37] The SFY 2008 DHHS-LME Performance Contract requirement is 24% or above.

Indicator 4: Timely Follow-Up after Inpatient Care

4.2 State Psychiatric Hospitals

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[38]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges January 1 - March 31, 2007); Medicaid and State Service Claims Data (for claims submitted January 1 - September 30, 2007); N=3,892 discharges

Statewide, twenty-nine percent (29%) of consumers discharged from state psychiatric hospitals received follow-up care in the community within 7 days. An additional 14% of NC consumers were seen within 8-30 days of discharge (not shown in the graph above; see *Appendix*). Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 18% (Mecklenburg) to a high of 37% (Johnston).

The established SFY 2008 target for follow-up care in the community within 7 days of discharge from a state psychiatric hospital is 42%, as indicated by the red line in the graph above[39]. None of the LMEs met or exceeded the target.

[38] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.

[39] The SFY 2008 DHHS-LME Performance Contract requirement is 28% or above.

The MH/DD/SAS Community Systems Progress Indicators Report and the Report Appendices are published four times a year. Both are available on the Division's website:
http://www.ncdhhs.gov/mhddsas/statspublications/reports/

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(919/733-0696)